COMMONWEALTH OF KENTUCKY
CABINET FOR HEALTH AND FAMILY SERVICES
DEPARTMENT FOR MEDICAID SERVICES

IN RE: HOME HEALTH TECHNICAL ADVISORY COUNCIL

SPECIAL-CALLED MEETING

October 13,2020
11:30 A.M.
All Participants Appeared Via Zoom or Telephonically)

APPEARANCES

Billie Dyer
CHAIR

Missy Stober
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Angie Parker
Lee Guice
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(Court Reporter's Note: At the request of DMS, all other participants appearing via Zoom or telephonically will not be listed under Appearances.)

AGENDA

1. Call to Order
2. Welcome and Introductions
3. Approval of Minutes
4. Telehealth/Remote Monitoring Update
5. NPP Orders for Home Health Update
6. MCO Supplies' Issue Discussion
7. Homebound Consideration in Traditional Medicaid
8. COVID/PHE Updates
9. Adjournment

MS. DYER: So, I think the protocol we're supposed to use is to introduce ourselves, or I don't know if it's allowed for anybody that wants to introduce themselves if they can. I'm not sure about that.

(INTRODUCTIONS)

MS. HUGHES: Billie, on other people introducing themselves, it's if they go to speak, we would like for them to introduce themselves for the court reporter. So, other than that, the visitors don't have to introduce themselves.

MS. DYER: Okay. So, we will call this meeting to order and just thanks, everybody, for being on and taking time out of your very busy schedules to be on with us.

I guess the first order of business, then, is approval of minutes from last time. Do I have a motion to approve the minutes?

MS. STOBER: Motion to approve.

MS. DYER: Okay. And a second for that?

MS. STEWART: Second.

MS. DYER: So, we'll go right on into Item Number 4, telehealth/remote monitoring

update and we're asking the Cabinet for that update.

MS. HUGHES: Billie, we were just getting off from another meeting. So, I'm not sure who all from the Department joined yet.

MS. DYER: We can skip on down. Well, actually, no. I'm not sure that we're not going to have to have the Cabinet for any items on this agenda.

MS. HUGHES: Lee Guice is on here and Angie Parker. I was trying to pull up the actual agenda also.

MS. DYER: Angie might be able to - what we can do is go ahead and go to Number 6 and, then, go back to 4 and 5, if that's okay to do that.

MS. HUGHES: That's fine.

MS. DYER: Number 6 is MCO supplies' issue discussion. And, Angie, that might be you and maybe Lee Guice, too, to give us an update, or does somebody on the Home Health TAC want to remind everybody of what that discussion needs to be? Susan, is that your item?

MS. STEWART: That is regarding billing limits for supplies from the different MCOs. They all have different quantities and we don't know

what those quantities are and it's different per MCO. A box of 4x4's is the example I use all the time. They come in a box of 50. One MCO's billing units might be 45, one might be 49 and that is not information that they share with us so that we know so when we get a denial, it's for the entire line item because we've exceeded their billing supply limits.

I did reach out to my business office to see if I had a new remit that I could share with you. And as of this moment, I don't have any new remits. That doesn't mean the issue is gone. It just means that they haven't gotten back to me yet because I just asked yesterday.

So, I don't think that the issue is resolved. I think our due diligence so far has been they send us a file. It has blanks. We send it back and say it's not accurate and we asked for the top 25. It still had blanks.

So, I think we're kind of at an impasse maybe, I don't know, but the bottom line is there are billing requirements out there and we don't know what they are and we don't have the data.

MS. DYER: Who can speak to that? Angie, is that something that you can speak

to?

MS. PARKER: Well, I know this has been an issue for a while. I think that came up again back in January when I was back attending the Home Health TAC.

MS. DYER: It's been on the agenda I'd say for two years actually, I think.

MS. PARKER: I was thinking that this was getting better or that the information - what was the last TAC because this wasn't on the agenda last time and it's been a few months.

MS. HUGHES: Hey, Angie----

MS. STEWART: It was on the agenda last time but I wasn't here. So, it got pushed.

MS. HUGHES: And I think two meetings ago, Susan was supposed to get us some additional information, if I recall correctly. And, you're right, she wasn't there at the last meeting.

The Department, we have worked and gotten you all I believe about as complete a list as you all are going to get. You provided us a list of codes and we asked and we've sent them to you from the MCOs.

MS. STEWART: But they're

blank. There's lines that are blank.

MS. HUGHES: Right. The majority of them were filled in. The largest percentage of them were completed and provided.

MS. STEWART: Are you all still having that same problem that we were having?

MS. DYER: We are not, but that doesn't mean everybody else isn't.

MS. STEWART: Again, I asked for information yesterday. I don't have it yet. If I think it's resolved, we'll remove it next time.

MS. PARKER: If you continue to see some issues, by all means, let me know.

MS. STEWART: Okay.

MS. DYER: And that's what I started to say. In between, if you do find that out, could you reach out to Angie Parker and maybe send that to Sharley, too, so you clearly see what we're talking about, Sharley, because I think when they sent that incomplete list, Sharley, you kind of went back through things and asked for a more complete list and I don't recall people ever getting that. So, I don't know.

MS. HUGHES: We sent out initially a great big, long, extensive list. Some

of the MCOs were longer than others. Some of them if I recall was - initially, I didn't think that maybe a couple of the MCOs had provided all of the DME or home health supplies.

And, then, you all provided us a list of I think like 50 items and we sent that to the MCOs and they sent that back to us. I'm trying to pull it up here at the same time. They sent it back to us and I did send that out to you all, and I think that is the one that was pretty detailed.

MS. STEWART: Sharley, if you have that, do you care to forward that out again because if my memory is right, then, that might have been sent right around COVID time and it could have just got lost in my shuffle.

MS. HUGHES: Okay. I'll have to see what I can find. I can't remember when we sent the initial one out, but I'll find it and send it back out to you all.

MS. STOBER: I remember a really big list. I don't remember when, though.

MS. DYER: That was a long time ago and, then, there was a revised one, but we've all been absorbed with the COVID for a very long time, too.

MS. HUGHES: But I think if you all are not seeing the issue now, I'm thinking maybe it's possibly been maybe not as large of an issue as it was at one time.

MS. STEWART: It might not be, Sharley. We might be able to remove this one before our next meeting; but if you will send that out, I would appreciate it.

MS. HUGHES: Okay.

MS. DYER: Are we able to go back to Number 4, Sharley, since we don't really know who is on here? Some of them are just phone numbers - the telehealth/remote monitoring update. I think that Stephanie Bates was going to be working on that maybe with you and Lee. I don't know. I know Stephanie talked about it last time.

MS. HUGHES: Lee, do you have any ideas?

MS. GUICE: I have sent a text to see if I can get any information; but because I wasn't here last time, I don't really know, and I'm sorry, Billie, about that but I don't really know what the conversation was and what the question is. Is the question, are we going to incorporate that ongoing after COVID?

MS. DYER: Evan, do you want to take that?

MR. REINHARDT: Sure. Yes, that is the question. We were just continuing this conversation. We had initially tried to broach this subject with Commissioner Lee about continuing telehealth services and, then, adding funding for remote monitoring.

And this sort of ties into Number 5 with the non-physician practitioner orders as well. So, there seemed to be some agreement that definitely for the non-physician practitioner orders, that that would be incorporated. We just didn't know when that project would begin.

And, then, telehealth, that was a bit more of a question mark because there would need to be some additional changes made and, then, funding for remote monitoring is kind of similar to telehealth.

So, we put all three of those together but, yes, the question was adding telehealth in and funding for remote monitoring as options for services post PHE.

MS. GUICE: So, on the non-physician provider issue, the federal government has

changed their regulation. And, so, we'll change ours; but because the federal government has changed theirs, they supercede us. And, so, it will be allowed. It is allowed now and it will continue to be allowed even after the pandemic.

So, it's on our to-do list but we have quite a big to-do list on the regulation side, believe it or not. So, it's not on fire because there is authorization at the federal level; and like I said, they supercede us anyway.

So, we are okay with it. We're fine with it because the federal regulation says it's permitted. It will be permitted after the PHE, for sure, no question.

But the thing about the remote monitoring, I believe the biggest issue is going to be trying to make sure that the fiscal impact to Medicaid is not - there's some other phrase that I shouldn't use here - but I'm just going to say is not too big, given the state of affairs at this point in time. Budgets are tight.

So, adding something that might seem like a new service while it wouldn't really be a brand new service, that is going to take a little doing and will take much more time.

So, if Deputy Commissioner Bates said that we were looking into it, I'm sure she is and we will continue down that road.

MS. DYER: Any followup on that? I would like to go back, Lee, at the CMS federal level, NPPs are allowed to do order writing; but we had understood - and, Evan, Susan, Missy, help me out if I need clarification here - we had understood that it still had to be on a state-by-state level.

Now, it is in the COVID-19 waivers that we can use an NPP or utilize an NPP's signature on orders currently because of the COVID waivers.

But our understanding had been that post no emergency declaration, etcetera or when the waivers were lifted, that we had to adhere to what our state said. Evan, is that what you thought?

MR. REINHARDT: Yes. Definitely the federal government has taken action and it is in effect both in statute and I believe in rule on a permanent basis, but states can be more restrictive. And even in the rule that CMS put together, they speak to that this is subject to

state restrictions on practice.

So, in our particular case, I don't believe it's statutory but it is in rule that a physician is the only professional listed that can order home health.

MS. GUICE: Right. So, that's the regulation about home health, okay? So, I think that the federal regulation talks about existing state licensure restrictions.

So, yes, we could be more restrictive. We're not going to be; but the other thing is that in some places, APRN's don't have the ability or even PA's don't have the ability to order services because their licensure has different restrictions on it.

So, the federal regulations have to allow for those variances because they can't tell a state how to license their health care professionals.

MS. DYER: For KBN----

MS. GUICE: We are going to put that in the regulation. It is going to happen.

MS. DYER: Okay. We know that surveyors make it be there before they will allow it when they do surveys for us. So, it has to be in

the regulation.

So, I guess it's up to each individual agency of what they're willing to do with that. I believe what you're saying, Lee. I get it. And in Kentucky, KBN says that for an Advanced Registered Nurse Practitioner and the PA rules are, too, based on what the physician allows them to do is what I understand from KBN ad the licensure for PA's.

So, if a physician says that they can order it, then, they can order it. If a physician restricts them, then, they're restricted; but under COVID-19 waivers, I think that's all kind of gone by the wayside.

We just want to make sure we have orders that stand a survey or whatever. And I know everybody's plate is full and running over. We entirely get that. We just want to know the status of where those regulations are and that kind of thing. It sounds like you all are working on them. That's what you're telling us, right?

MS. GUICE: Yes. That's what I'm trying to say. We're working on them but they're not at the top of the list. I'm sorry.

MS. DYER: They're probably at

the home health top of the list, in the top ten for us.

MS. GUICE: I understand that.

MS. DYER: And I would also like to go back to something on remote monitoring. Those are two separate things just to clarify to make sure everybody on the call is understanding of that in our minds, in the way we're presenting it. Telehealth would replace a visit.

So, I don't know if there's any advocacy there when you all are looking at regulations to help understand that, but I think remote monitoring would be excellent and it would probably decrease the amount of visits - Missy would agree with that, I think, for sure and probably everybody else - or it could, but it would also provide more monitoring of the patient and be more specific based on that person's diagnosis.

But telehealth would be - and I think remote monitoring has kind of gotten folded into telehealth and that's all fine and good - but just to reiterate that telehealth in home health for whatever services that home health agency can provide that is appropriate for the patient, that that would be in lieu of.

And I get what you're saying. Money is tight everywhere, Lee. That's a very good point. We all know that. The State doesn't have a lot of money. Nobody does. We're all lean and whatever, but it would just be a replacement, not an additional visit.

Evan, is there any other clarification you want to say about that or anybody else?

MR. REINHARDT: And Missy will jump in here, too, I'm sure, but the case to be made for both telehealth and remote monitoring is that they help prevent escalations in care and additional costs that might come in the bigger picture.

So, that's the point we want to emphasize there is you can turn hospitalizations kind of upside down in terms of the number that happen. At least some of the evidence we've seen, you go from one in five with CHF and COPD diagnoses to kind of one in twenty when you employ remote monitoring. And having telehealth as a wraparound there, too, would be even more helpful.

So, that's our thought process. We definitely understand that the budget is tight, but you also have to think that if we can

be smart with the employment of new and different technologies, that would be helpful, too.

MS. STOBER: And I would add to that. We've had some experience with our Medicaid and Medicaid MCO patients. Many of those patients and the homebound consideration, the patient doesn't necessarily have to meet the homebound criteria, but we have younger patients who are very technologically savvy who are a little bit more used to being mobile than some of our really elderly patients. So, our age cohort is lower in that.

And you could look at a telehealth visit and it does cost less to do because they don't have to travel to the patient's home, especially when you're in a rural area where you would have signaling and that's improving, and you could check in with the patient more for almost the same cost.

You could have a lower cost telehealth visit, a little bit lower and get more touch points with your patients which would help to decrease hospitalizations.

That's the same point with remote monitoring for your heart failure patients is remote monitoring, while it may be considered a new

service like we're adding, okay, I got a cut and a color on my hair and now I'm going to add a blow dry, it's really not like that.

It's a service that has plenty of research data about its ability to decrease cost of hospitalizations, unnecessary hospitalizations.

So, if you're just looking at it as an added service on a menu item, that's really the wrong way to think about how we're going about these things in the future with technology.

MS. GUICE: So, just let me interrupt here. For some reason, it sounds to me like you think I'm not on board with your recommendations here, and that couldn't be further from the truth because I am on board with it.

I do strongly believe that telehealth, we've had the opportunity now to show that telehealth works and is an important aspect of service. So, I'm completely on board with that as long as we can show that it works and how it works.

And I believe I said, even though it is not a new service, people will view it as a new service adding remote monitoring.

So, I'm completely on board with it. My point that I was trying to make was

that while it's on the top ten list of Home Health TAC and providers, the regulation about NPPs is not on the top ten list of Medicaid policy right now. It will move up as other things get moved off the top and we are going to do it.

And we are trying our best to look at, as we have the resources, your other recommendation; but I have to be fair with the information that I have and that I know that we may get push-back and we may get push-back on adding a new service. That's all. That's all I was trying to say.

And, Billie, you're making the notation that telehealth and remote monitoring were two separate items.

MS. STOBER: And we appreciate it. I don't want you to think that, at least myself and I don't think any of us here, trying to think that you're not in support of that.

I think we're trying to help with is there any way that we can help with any information or data we can have to help support that it could be considered budget neutral or even budget positive to sort of realign how we do things. So, that was my point.

MS. DYER: And I'm not saying that remote monitoring is not important - it is - but it is currently not something that is reimbursable while visits are. So, just really we're trying to make the point of explaining why we feel like it is so important, Lee.

So, it's not anything personal about what we're hearing you say. We're hearing you say you're working on it, and we realize there's a boatload at DMS but our focus is home health.

Now, I will have to say that I do not think that we can have a less reimbursement for all visits in telehealth because some of them are comprehensive and that you're doing the exact same thing. And for like a contract therapist, we're paying the exact same money we were before.

So, if there was ever any discussion about reimbursement, I think that we would have to look at Kentucky Home Health and make a recommendation, if you all wanted us to, about if there could be a tier of visits or something like that to consider based on what Missy said because some of them will be probably as comprehensive - they should be - or more so than a visit even that we're making now because you have that person right

there.

So, I just think that if there's discussion to be had, and probably what we're all offering, Lee, is just to say that we're here. We're willing to help support in any way what is needed for telehealth and telemonitoring or one or the other or both. That's where we're coming from, if there's anything that we can add to or bring to the table in any way.

Okay. So, I guess we're ready to move on to Number 7, homebound consideration in traditional Medicaid. And, Evan, I don't know who had brought that up because evidently we're - is that you, Susan? You raised your hand.

MS. STEWART: Yes. That was me.

MR. REINHARDT: I passed the example on to Sharley and we got an answer at least preliminarily and, then, I sent that over to Susan. So, that's kind of the update from my end.

MS. STEWART: And I shared with my team and explained that if they had any other issues to let me know, to try to document anything we're speaking to that was denying for that reason. So, I have not had any other feedback since I got

the feedback from Evan.

MS. DYER: And what was the conclusion of that just so that it's in the minutes and shared?

MR. REINHARDT: So, the homebound definition, it hasn't changed. The feedback was that it's a consideration as a part of a determination for services but no change has been made to the homebound status overall and from a global perspective.

MS. DYER: And that does pop up occasionally. It may just be a training thing with whomever we speak to but I'm not sure.

MS. STEWART: And I trained my people to push back.

MS. DYER: To make sure that they're fighting for that visit for that patient.

MR. REINHARDT: I can pull the email up here. Whereas, an individual's overall health is assessed when determining the need and approval of home health services. Being specifically "homebound" is not an absolute requirement. What is is that the home health services must be provided at the individual's place of residence. So, that was the clarification that

was made.

MS. DYER: Thank you, Evan. Any other discussion on homebound or anything else we need to say about that?

Okay. Number 8, COVID/PHE updates and we have the Cabinet marked on there. Have you all heard anything about an extension to the emergency declaration or any other COVID-related issues?

MS. GUICE: Secretary Azar - I think that's how you say his name - of Health and Human Services, he issued an extension on the public health emergency until January 23rd. So, that's the longest it can last but he issued that last week. So, we're still operating under emergency circumstances.

MS. DYER: That's quite a relief to know. I don't think we had that information at all, did we, Evan? It hadn't trickled down.

MR. REINHARDT: No. That's good to know.

MS. STOBER: So, are you saying it could be extended through January 23rd, but at any point, it could be discontinued?

MS. GUICE: No. It is extended. Ninety days is the stand limitation. The Health and Human Services' Secretary, HHS, they're in control of the length of the public health emergency. So, when they issue an order, the longest it can stand is ninety days. They can stop issuing the order at some point but no one expects them to do that.

MS. STEWART: So, can they come in in January and have another one or are you saying January the 23rd is it no matter what?

MS. GUICE: No. Every ninety days, a public health emergency is issued. It can only last for ninety days.

So, we've had a new public health emergency issued three times, I think, three or four times since the beginning of the year. I don't do calendar months as easily as some other people, but the longest they can stand without being reissued is ninety days.

MS. DYER: So, everything stands as it is and there were no changes to the COVID-19 waivers, Lee?

MS. GUICE: Everything is the same.

MS. DYER: Okay. Any other questions, comments on Number 8?

MS. STOBER: Billie, before we exit, I want to go back to what I was saying about cost and things.

I want to make it very clear that we've not had an increase in our rates for as long as I can absolutely remember, and what we're getting paid nowhere covers our cost of care for our Medicaid patients.

So, I want to make sure that you know that. My point was that the collective dollars we spend on the health care of these Medicaid patients, then, we could look at, that if there's some way we can help to share with the Cabinet or whoever is looking at this, that we could decrease overall cost of care by realigning care using appropriate technology and the use of less costly services like home health, but our reimbursement has to be commensurate with the increase in cost that we've had all along.

So, I want to be on the record to make sure that you understand that purpose; but I think if we can help in any way to help look at decreasing overall cost of care instead of in silos,

which does happen when at least I've had experience with talking to other payor sources as well. They get very segregated in terms of I'm only looking at my cost of hospitalizations or my cost to home health and we've got to think about it in an overall person cost of care.

MS. PARKER: I will say the Commissioner is all about data. That's always helpful to evaluate these types of things which is what we're going to be doing and are doing regarding how to continue with telehealth. Where is it working, where is it not and those types of things.

So, if you have data that shows this, I mean, I'm talking about not nationally, I'm talking about your data that kind of shows this, that would be very helpful.

MS. STOBER: Well, Angie, there are many different payor strategies across the country and some of them are involved in the state. With Accountable Care Organizations, there are many of those in the State of Kentucky. There are ones which are shared services, either shared reimbursement and others that don't have a penalty.

And I am confident that there are probably multiple organizations within the State

of Kentucky that could help you to show how grouping together services and looking at overall cost of care and using lower cost care like home health in a bundled payment sort of way could show some of that.

I know with the LHC group, we have Accountable Care Organizations here in the State of Kentucky and have some patient cohorts. There are other health systems that also are involved in that in Kentucky.

MS. PARKER: There's no ACO's with Medicaid.

MS. STOBER: No, but we have Medicare population and there are payor sources who have that as well.

MS. GUICE: So, the good thing, Missy, is because you're there, you're in that world, what we're trying to ask you is if you want to recommend something, show us some data.

MS. STOBER: Sure.

MS. GUICE: Put it together and let us have it so we can present it to the Commissioner.

MS. STOBER: So, Evan, maybe that's something we can talk about collectively offline because I think there's probably two or

three folks that would have some experience in the state. I won't say Medicaid in Kentucky because we don't have any other option but the people that we're caring for with you because it doesn't exist, but certainly people in the State of Kentucky.

MS. DYER: Okay. Any other comments, discussion?

MS. STEWART: I have one question. Will our meetings remain virtual for 2021 or what is the plan for that?

MS. HUGHES: I was actually going to go back. It's up to you all. Some of the TACs that have been meeting via Zoom have sent me emails hoping that they can continue to go Zoom because it keeps them from having to travel and some of them be out of the office all day long for a two-hour meeting when they can attend via Zoom, which, of course, that's an option you can do. So, basically, it's up to each individual TAC.

Now, I was going to mention - I think you all are scheduled for December to meet, if I'm not mistaken - that we wouldn't want to go ahead and schedule the meetings at your next TAC meeting for 2021.

What I want to find out is if

we go ahead and schedule them now and we say they're going to be via Zoom, I want to find out if that should eliminate it being a special-called meeting, but I'm not an attorney, even though I play one sometimes.

So, I want to get it official from the Governor's Office that if we schedule them as Zoom because if we do, I mean, the meeting, then, opens back up to what they were previously that you don't have to stick strictly to the agenda.

So, I was going to send an email early this morning and actually forgot about it and got busy doing something else; but at your all's next meeting, we will want to go ahead and schedule next year's meetings, and it's up to you all as to whether you want to do them in person or via Zoom.

MS. DYER: We'll have that discussion and come to a conclusion before the December meeting. I think some of the answers today, I'm not sure that I would need to on behalf of the Home Health TAC request a November special-called meeting or not but we'll discuss that, too, Sharley, and get back with you.

MS. HUGHES: Okay.

MS. DYER: All right. Anything else? Do I have a motion to adjourn?

MS. STEWART: Motion to adjourn.

MS. STOBER: I second.

MS. DYER: Thank you.

MEETING ADJOURNED